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Unlearning and public services - A case study with Vygotskyan approach

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ABSTRACT: *All successful public service innovations require learning and just as importantly and often more deeply, unlearning. This research investigates the unlearning of health professionals focusing on the issue of why and how does unlearning happen at an individual level for healthcare professions in the transition from product logic to service dominant logic (SDL) at Tampere University Hospital in Finland. Applying a qualitative single case study method, problem-centred unlearning framework with narrative approach, which facilitates understanding of how the informants perceived the service transition process. We identified three distinct unlearning narratives and we recognized barriers and enablers to unlearning in the healthcare service culture and context and suggest ways in which these might be overcome. Results of the study shows that deep and radical change in public healthcare services is possible, by applying distributed leadership and allowing individual actors time for reflections, mind-wandering, listening, and learning from users and discourse between professionals.*

Keywords: Unlearning, problem-centred unlearning, change management, service dominant logic, public healthcare service

Introduction

Hospitals, like many public organizations, have tried to move from service product dominant logic toward service dominant logic (SDL) in many countries (Osborne, Radnor & Nasi 2013). In the context of health, SDL is an approach, which integrates services and products/goods as a service process. In the field of healthcare, patient-dominant logic would be an appropriate definition – highlighting both dimensions of service: the service itself as well as the ‘service product’ provided by the personnel in healthcare organizations. As a part of SDL, digitalization impacts health care at all levels: ways-of-working and processes, resource allocations, policies and the ways through which health is understood, experienced and measured (Virtanen & Stenvall 2018). The concept of health evolves towards more comprehensive concept of well-being and this process consequently affects policy making in the field of public policies related to health and well-being issues.

It remains unclear how the shift from service product logic to SDL occurs in the health or other sectors. In the studies of transition to SDL, concentration has been on the ideology of SDL and the changes of service systems (Osborne, Radnor & Nasi 2013; Virtanen, Kinder and Stenvall 2018; Laitinen, Kinder & Stenvall 2017). There are many studies around what SDL means for service users including changes in professional identities and working methods, such as Tuurnas, Stenvall and Rannisto (2016). Hence, we hear how it is more difficult to alter attitudes than behaviour, structures or technology; public service workers may conservatively stick to old ways-of-working, roles and relationships whereas new frameworks – like SDL - concepts, metaphors and governances require new ways of thinking and feeling (Krotel et al 2017). In this

paper we use unlearning to understand the transition from product logic services towards service dominant logic.

Our contribution is to emphasise the importance of unlearning in a shift from service product logic to service dominant logic, and to illustrate some important aspects of unlearning processes. We present a new Vygotskian learning framework to analyse unlearning in service model changes.

The research question

In this paper, we are interested in the unlearning of health professionals focusing on the issue of why and how does unlearning happen at an individual level for health professions in the transition from product logic to SDL – our research question.

Health professionals can be considered as street level bureaucrats; they have considerable autonomous discretion over how the service system works in practice (Virtanen & Stenvall 2018:103; Virtanen, Laitinen & Stenvall 2017; Baviskar & Winter 2017). Our starting point is that it is impossible to move to new kinds of thinking if we are not able to change professionals' mindset. Unlearning is an acceptance that old ways of thinking will no longer lead to acceptable explanations and solutions; they have become in Hardin's (2002) phrase a *crippled epistemology*, which the process of unlearning helps replace.

Secondly, we assume that product logic and SDL are related in unlearning. We dispute the notion that unlearning is a separate process from learning and also Klein's (1989) view that portrays unlearning as discarding, degrading, forgetting or parenthetically parking of knowledge.

Instead we take a Vygotskian (social learning) perspective: learning and unlearning occur in the same processes, however distinctively unlearning *always* requires a deep re-examination of existing frameworks, concepts and metaphors and not simply the overlay of sense-making or addition of new information or ideas. Professionals might unlearn service product logic and learn SDL in the same process.

Our aim is not only academic inquiry; we believe that by understanding how and why unlearning occurs we can perhaps make the processes more efficient and thereby improve public services.

There are methodological challenges in understanding the unlearning in professionals' mindsets when shifting from product logic towards SDL. The process of unlearning is difficult to capture in health care because it involves personal and emotional processes (Rusmer & Davies 2004). In this paper, we use a narrative method to understand unlearning, which is always influenced by the context and culture in which it blends old and novel experiences. In a similar manner to Clark (2010) we seek to understand unlearning and learning through narrating it.

We begin by briefly outlining our framework for analysing unlearning highlighting problematic issues and then present the Vygotskian approach to analysing unlearning giving examples of previous research using a similar approach, such as Engeström (1999). Mainly, however, Vygotsky's (1934) approach is used in analysing learning and not unlearning. Following a short methods section, justifying our interpretative inquiry approach and narrative method, we then present three new narratives elucidating unlearning by hospital practitioners, which we then

analyse – triangulating with previous research literature – and from which we draw theoretical conclusions and suggestions for management practice.

Vygotskyan framework for unlearning

As Sherwood (2000) has noted, the term unlearning is mostly favoured by consultants and rarely empirically tested, and literature disputes definitions of unlearning; see for example Tsang & Zahra (2008). Most definitions, – as Brook *et al* (2016) note, follow Hedberg (1981) in portraying unlearning as a part of cycle in which knowledge grows, become obsolete and is discarded. Hedberg (1981) argued that in organisations old knowledge is *discarded* to make way for change. Note that his unit of analysis is the organisation and not cognitive individual humans. Whilst accepting the idea of unlearning, Newstrom (1983) viewed it as eradicating barriers to new learning, arguing against what he terms the *clean slate fallacy*. An alternative interpretation of unlearning by Klein (1989) disputes Hedberg's idea of overwriting old knowledge with new, suggesting that unlearning *degrades* old knowledge; this is similar to Duffy's (2003) relinquishing old ways.

Our argument is that learning and unlearning are part of the same cognitive exercise, however, it is useful to conceptually differentiate between them since while 'new' learning enmeshes and use 'old' experiences (whether knowledge or ways of conceptualising and thinking), unlearning consciously excludes 'old' learning, building new frameworks and bodies of knowledge.

Unlearning in practice means consciously not thinking or acting in 'old' ways.

Unlearning as discontinuity such as “forget that, do this” is of questionable usefulness in manufacturing or (relational) services. Such approaches lead to Bettis and Prahalad (1995) proposing that rates of unlearning can be quantified, and Greiner (1987) ominously referring to *explicit dissuasion*. We argue that learning necessarily evaluates ‘old’ knowledge in the light of new information. Hislop, Bosley and Coomps (2014) state that unlearning is unconscious, whereas learning is a conscious act; alternatively, we argue that both learning and unlearning occur unconsciously, especially as Merton and Barber (2004) argue, for the *prepared mind*. Reviewing pedagogy literature, we find no robust defence of unlearning as a separate cognitive category from learning. Unlike Howells and Scholderer (2016), who as psychologists dismiss the idea of unlearning, our view is that all learning (for adults) involves unlearning. Huber (1991) too challenges concepts of unlearning, yet adheres to the notion that (non-cognitive) organisations can learn (when at best the term *learning organisation* is a metaphor). Other researchers suggest that somehow ‘old’ learning is parenthetically suspended (Klein 1989; Laitinen, Piazza & Stenvall 2017) or discarded (Tsang & Zahra 2008; Antonacopoulou 2009). We conclude that unlearning, as a separate category of cognitive activity from learning has no theoretical foundation or empirical support: we now turn to consider theories of learning that explain unlearning. Our approach includes learning/unlearning building upon Vygotsky’s (1926; 1934; 1987) socio-cultural theory of learning.

Vygotsky (1934) emphasises that learning is socially constructed; making sense of new artefacts (*activity*) is mediated by context and culture alongside previous learning inside zones of proximal development (ZPD; see Wertsch 1985; Lave 1988; Daniels 2001). While referencing

experience in making sense of new learning, Vygotsky emphasises cognition more than (for example) Argyris and Schön (1996) or Wenger (1998). His stance is similar to Dewey's (1938) experiential or pragmatic learning and Kolb's (1984) experiential learning cycle and learning inventory. Unlike knowledge management theory, the social learning approach does not rely on the problematic distinction between explicit and tacit knowledge; it focuses on how knowledge is created rather than how it is archived, distributed and managed. Vygotsky's social learning approach involves active learning and as Raelin (2008) points out, ideally suits action research and learning.

Consciousness for Vygotsky unifies all cognitive learning processes (Nardi 1996). For Vygotsky, all learning is social: cognitions always reference culture and context (Wertsch 1985) – as learning is *internalised*, individuals create new combinations and interpretations resulting in new knowledge (Daniels 2001).

Using Vygotsky's (1978) approach Cirny (2015) highlights the role of social interaction in reconstructing prior knowledge. He explores the ZPD as the difference between what a learner can do without help, and the capabilities of the same learner engaged in interactions with other people bringing other sets of knowledge. The problem/new information (in our case in the form of a new service model) becomes an artefact interrogated by learning in the light of experience, learned frameworks and concepts and emotions constituting a ZPD. Such learning always involves emotional reattachment (Vygotsky 1926:118): it is affective, the result of cultural predispositions. For unlearning, emotional reattachment is as important as cognition. Zones of proximal development are always socio-cognitive space in which the new solutions are contrived

involving as Wells (1999:331) argues *acting, thinking and feeling*, which Engeström (1999) calls *expansive cycles* of learning. This approach is summarised in table-1.

INSERT TABLE 1 ABOUT HERE

Table-1: Summary of Vygotskian approach to unlearning

In summary, our Vygotskian approach means views learning and unlearning as the same process in which cognitions and emotional attachments are reviewed in the light of new frameworks and information. This occurs after acknowledging the need to change from an unacceptable existing order: Hardin's (2002) *crippled epistemology*. In short, we offer a new way of thinking about unlearning for which we offer a new processual conceptual framework for understanding a shift from service product logic to service dominant logic.

Method

As Engeström (2007) notes, *context is everything* in learning. We have collected data from Tampere University Hospital (Tays), which provides primary, emergency, chronic and specialist care to over one million Finns. Like all Finnish hospitals, Tampere University Hospital is currently undergoing restructuring and piloting partnerships with private sector. Tays is seeking to replace product logic with a SDL i.e. from supply-push to a demand-pull, using the involvement of patients and their families to fundamentally redesign services often also

involving private or third-sector organisations. The keyword is patient-oriented services, focusing on the safety, ease and comfort of treatment.

Brand (2015) following Rushmer and Davies (2004), gives three reasons why they believe transformational unlearning is difficult for health care providers: (a) health professionals' training emphasises rationality in decisions without consulting emotions; (b) valued stability embedding risk assessments embedded in organisational memory are challenged by deep cultural change; and (c) the uncertain and possible unintended consequences of unlearning are avoided by an organisation comfortable with patterned certainties.

We use an interpretative inquiry approach (Rabinow & Sullivan 1985) in this single case study (Yin 2009), structuring data into facts using our analytical framework. This *makes meanings* (Yanow 1999) that are highly contextual in the sense that instead of universally applicable *demonstrated true belief* we create meaningfulness valid for the context and culture of the study. Validity and trustworthiness in qualitative research rests on honestly gathered data, honestly interpreted, respecting alternative interpretations (Angen 2000).

Single case study is our strategy in this study and the approach seems fit given the research objectives of the study as well as the nature of healthcare fields' complicated context and the topic of our investigation (Halinen & Törnroos 2005). The aim is to gain rich understanding of the phenomena under scrutiny in its real-life context. Our aim is not to generalize statistically, instead we aim to expand unlearning theory and achieve analytical generalization. Case studies also have distinctive value in social sciences when practical implications are needed.

Furthermore, the descriptive nature of this study also justifies the single case study method.

(Suomi 2015; Saunders, Lewis & Thornhill 2003; Yin 2009).

Guided by Czarniawska (1998) and Boje (2001) and following a presentation to Tampere hospital staff on unlearning, governances and innovation in late-2016, we invited nine volunteer medical practitioners in Tampere Hospital, each of whom expressed an interest in unlearning, to narrate their stories, a procedure recommended by both Rhodes and Brown (2005) and Bryman and Bell (2012:102). The interviewees (see table-2) represent as Aberbach and Rockman (2002) suggest a diversity of roles and authority, while each has substantial experience. As Brown (1998) notes, cameo narratives from the same group may elucidate tensions and/or disagreements. Interviewing in May 2017, we adopted the cognitive conversation conventions (McDowell 1998) inviting interviewees to use their own terminologies, sequencing and causal connections. Our work was non-interventionist and granted level-1 ethical consent.

INSERT TABLE 2 ABOUT HERE

Table-2: Interviewees

The main interviewee selection criterion is their personal experiences in shifting from product to SDL; most have been moving in this direction before the Hospital adopted this change strategy. They described during interviews what how and why the transition occurred and what it meant to them in personally. Our data coding from patterns and repetition include references to service users, emotions, piloting/experimentation and meaningful work.

From the many stories of change involving learning and unlearning, including switching emotional attachment, we have selected three as deeply illustrative of unlearning processes in Tampere Hospital, each resulting in service innovation and new governances. These we entitle (a) Taking babies home; (b) care in the community around the holistic patient; and (c) patient-centred care or democratic medicine. Almost all of our interviewees talk about these stories. These three stories give us a comprehensive picture on unlearning in a shift from product logic to SDL.

Taking babies home unlearning

Taking Babies Home: Individuals Unlearning at Tampere Hospital

Listening to patients was the stimulus for individual unlearning by maternity nurses.

Interviewees 1, 2, 3 and 4 tell the story that until the mid-1990s after childbirth, mothers returned home leaving their babies in the care of Doctors and Nurses a system that gradually altered, however, sick babies continued to remain in hospital. As I-1 says, *I realised we need to be more open. My heart told me things were wrong.* Finding that other nurses agreed, since 2005, all but the most ill babies go home with their mothers, with Nurses explaining the care regime and regularly visiting babies at home. Ill babies stay in hospital along with their mums. Interacting with non-hospital professionals, I-4 suggests, helps Nurses focus on customers.

I-3 describes these changes are shifting from *Doctor-centred care to patient-centred care*; I-1 says that Doctors propose new medical procedures, but care practices are driven by *nurses listening to patients*. Another example is breastfeeding, which according to I-3 Doctors viewed as marginal, while nurses took up as an important part of early parenting.

I-3 says that previously, *I thought we were customer orientated, but we didn't really ask them about their care, we didn't see them as partners, we asked how are you, we didn't agree care package.* I-2 describes the role of nurses now as *teaching mums how to look after their individual baby: educating, supporting and teaching* a process I-1 summarises as *discussing not telling*. She says she was looking for changes to make all parents happier with birthing processes and found that *listening to the mums* gave the answer: keeping all babies and mums together. For I-2 *providing care whether in the hospital or community was a new insight.*

Baby care is deeply emotional, especially sick babies; understandably enabling parental care instead of providing care was a major emotional adjustment for maternity nurses. Several discussed how in changing, as I-2 puts it, *the heart took time to catch up with the mind*. Only after seeing the pilot success of enabling mums to provide care did I-3 realise that her *deepest emotional attachment* was to the quality of care not providing the care. All interviewees agreed that emotional re-attachment was easier for younger nurses who had spent less time under the nurse-care regime. Also, the nursing education and training has developed from earlier decades supporting junior staff in accepting changes of work processes. For I-1 the emotional re-attachment journey meant adjusting how she felt as a professional: *my role altered, less hugging babies to more teaching mums.*

Taking Babies Home: Unlearning in a Hospital Organisation's Active Learning System

I-2 points out that research hospitals in Helsinki and the US formally conduct R&D projects and that while some Nurses and Doctors scan research literature, innovation in Tampere proceeds by

careful piloting. Nurses informally discuss new ideas, especially I-1 says from abroad. Distributing unlearning occurs informally, I-2 says, no formal time is allocated to share new thoughts. The unlearning around taking babies home occurred over 10 to 20 years, I-3 says because Maternity is quite different from other departments since unlearning is personal. Hospital Management knows that when the nurses suggest a change such as taking babies home, they have fully thought through the idea and incrementally tested it. The Nurses believe (I-1) that local Councils are not keen on taking babies home because it transfers cost and responsibility; Nurses however *know the midwives and social workers* and have confidence in street-level care systems. Distribution of unlearning is then informal before it is formalised and occurs only over a long period of trialling.

Taking Babies Home: Unlearning in a Hospital's Context

Nurses in the Sick Babies unit see the pace and direction of their unlearning as shaped by the culture the Maternity services and in turn altering that culture. I-2 for example highlights the *slow and careful incremental steps* towards taking babies home. Having unlearned medically dominated care, as I-3 says, *Our calling has changed. Now we help mothers to take responsibility for their own child, its wrong to separate them, we enable that bonding.* The Nurses recognise this means a new outward-looking culture for the Hospital. As I-2 says, *we need to get rid of silo working, for example in joint training with midwives and social workers.* They are determined to achieve external accreditation in the form of the WHO/UNICEF Baby-Friendly Hospital certificate. In summary, the old culture meant that unlearning by Maternity nurses was slow and careful, however, having made the switch and gained the support of Doctors and Administrators, the Nurses are now helping build a new culture that looks outwards.

Taking Babies Home: Culture and Unlearning in a Hospital Active Learning System

The nurses point out two cultural changes in the hospital. Firstly, as I-3 notes that nursing and other staff expect patients to actively participate in their own health care; *its patients and families that makes things happen, nurses have to step back, we used to be the doer, now we're the educator and enabler*. Secondly, twenty years ago Doctors and Managers did not, as a matter of course, listen to patients' voices as mediated through nurses, today that is expected and welcomed as a source of improvement. I-1 believes *Finnish people have become more self-confident and less dependent on being told what to do: our culture has changed and the hospital has changed with it*, she says. *Now everyone is treated as an individual, not a standard patient*.

Care in community and unlearning

Care in the Community - Individuals Unlearning at Tampere Hospital

All interviewees spoke positively about caring in a community setting as necessary for the holistic well-being of patients. The Maternity Nurses (I-1, I-2, I-3 and I-4) recognised that *taking babies home* meant on-going care and tuition in the home. I-8 was taking part in a lean thinking programme in 2013 that investigate the 'voice of the customer' when she realised, *I feel comfortable working in a hospital without walls, providing care in the community – its better for patients and better for the hospital*. She now works with Discharge Nurses and outside agencies creating care packages that return patients home appropriately as quickly as possible. *Its better for the patients and reduces bed-blocking and roundabout patients*, she says. When I-5 began to deeply think about community care he realised *this was a new way of providing improved care; it changed my whole mindset*.

Individuals flourish as care professionals because they are emotionally committed; altering emotional attachment from hospital-oriented care to care in the community is therefore a big step. Several interviewees comment how changed emotional attachment deepened over up to a decade. For I-5 the switch took a year, the Maternity Nurses carefully felt the new way forward over a decade – and are still making changes. I-9 interesting comments how hospital policy and national Government policy followed and did not lead practice, *we were doing care in the community and only afterwards did it become hospital policy and then we heard it from the Government.*

Caring for the holistic person located in their community has different connotations for different hospital units. Interviews, (all of them), reported how having themselves intellectually and emotionally accepted the idea, they realised that other staff had arrived at similar conclusions and importantly senior doctors accepted the change as I-5 and I-6 record. Distribution of the care in the community concept was never limited to within the hospital. I-9 remarks how open Social Workers were to the idea and as we noted above, the maternity nurses began discussing the idea with new mothers. *It makes life more complicated not simpler, I-8 says, but we all realised it makes sense.*

Care in the Community - Unlearning in a Hospital Organisation's Activity System

Currently, like all Hospitals in Finland, Tampere is undergoing regionalisation involving amalgamating units and promoting service integration with social care agencies. Both the City of Tampere and the University Hospital have adopted these policies and as I-5 notes *all staff are*

thinking about what these changes mean. For many units in the hospital there is a happy coincidence of bottom-up change engaging with top-down policy: hence several interviews view these changes as building on a trajectory of practice already in place. I-8 says, *we already do it, its just that its now officially recognised.* There are staff, as I-7 notes, less involved, however she is clear that involvement is encouraged and everyone is affected for example as records and documentation alter to facilitate community care.

Care in the Community - Unlearning in Tampere Hospital's Context

For I-7 the new context or re-organised healthcare and City-partnership are welcome as they reflect Tampere Hospital's direction of travel and the work experience of its managers: *the best suits used to wear white coats*, he quips. In his own case in the new context he believes, *I'm a better manager because I've done that work.* He and other staff members are eagerly engaged in the street-level work of integrating care plans, inter-linking (not sharing) databases and negotiating new terminologies. *The new context doesn't have organisational boundaries*, he comments, *it helps our patients' customers orientation.* I-8 similarly views the new context as an opportunity, in her case for shared training and learning new approaches, such as involving (where appropriate) the Police and life-long learning providers. Over 85% of staff, I-9 suggests, are involved in the new working arrangements, for other she says *its important to share personal experiences as a way of reducing fear of change especially working with outside professionals.*

Care in the Community - Culture and Unlearning in a Hospital Activity System

A hospital is home to multiple professional groups, each with their own heritage, epistemology and ethical code. It is therefore no small thing to institute new close working arrangements with

non-hospital professionals (Laitinen & Stenvall 2016). As I-9 notes, this needs *continuous collaboration; not just training, its an on-going process negotiating close working based on mutual respect*. At a wider cultural level, she sees care in the community as part of the modernisation of Finland's welfare state – *joining things up for the benefit of customers*. Similar processes with the health service, I-5 notes *involve recognising and respecting different disciplinary cultures*. Will there be misunderstandings, resource allocation issues and turf-wars, I-9 is certain there will be, however, *if we are guided by our customer at the centre approach, we'll get there*, she says.

Patient-centred care and unlearning

Individuals and Tampere Hospital's Unlearning Activity Systems

We found diverse individual stories about how and why deep individual unlearning occurred. The Director of Nursing is too busy for deep thinking at work. She was stimulated to think of patients as customers in her MSc and later PhD work, *Talking with others, mind-wander while walking with dogs in my own time, no deep thinking at work* (I.9). When she was promoted and thinking over what difference she could make, she decided that helping make patient-centred care a reality would become her mission. Her ideas evolved over twenty years.

Other interviewees can precisely give the moment when they realised that becoming patient-centred was a new way of working. For I-7, it was during a training course seven years previously; for I.8 it was when cogitating over remarks from teenagers when asking for their ideas on how to improve care – she suddenly realised a patient-centred approach make her work more meaningful.

I.6 was musing about the meaning of a role-play exercise during a 1995 EU health promotion project discussing what *partnership with patients* actually means in practice. She says *I knew in theory it was an epiphany for my practice – an eye opener*. Upon returning to work, she was discussing patient's complaints that they staff were often *late for appointments*, *I realised often 30 minutes late; we responded by ensuring we see people on time*. Over the next twenty years she says, *I unlearned that the professional is always right, that I don't need to have the last word, if I'm patient enough to pose the right questions. This is now my approach not only with patients, but also with groups of other professionals*.

For I-5 too discussion with patients, some twenty-years ago was a key unlearning point: he was discussing with a group of patients' operation he had performed that had been technically successful and wondering why the patients felt the service was inadequate. He suddenly realised the importance of how the patients felt about their treatment and says *it took time for me to emotionally arrive*.

For I-5 aligning *individuals wishing patient-centeredness with organisational processes* has *taken twenty-years, joking that they (patients) used to phone and we'd then send a formal letter; now we do as much as we can conveniently either face-to-face or over the Internet*. I-7 discussed terminology at length as symbolic of the change saying that 'customer' is insufficiently nuanced: children are co-workers and not simply customers exercising choices. For her, the key unlearned change in the organisation is *not co-working which always happened, its listening to the patients and knowing the hospital expects that*.

Culture and Unlearning in a Hospital Activity System

As a Doctor (I-6) for over twenty years the hospital now views the patient more holistically – their family and community are part of diagnosis and prognosis. She feels *collective memory hospitals is like the military, so difficulty getting patients to reduce distance means not only the organisation altering its expectations, the patient's expectations too have altered*. Now she is comfortable that the Hospital *does not expect me to be bossy and instead work, listen and learn with children and colleagues*. She believes the Hospital as an organisation has changed fundamentally towards being patient-centred *because people like me became role models; the main thing is learning-by-doing and in a hospital pecking order that means Doctors legitimising the new ways of working*.

Individuals learn within organisations, which in turn exist in a socio-economic context. I-5 feels that shifting from we know best, to being patient-centred reflects a changed mood in Finland: *services are always about people*. His journey was not difficult, but slowly recognised that *being patient-centred here was the same as quality of service in a shop, bank or sports club*.

Other interviewees also describe how unlearning that professional competence is insufficient requires a deep emotional change of attachment. I-8 says, *it took me a long time to think of patients as customers, just like I'm a customer of my hairdresser and expect to be listened too*. For me the customer is the teenager, their family and the community. Using the phrase *democratic medicine*, I-7 says that *while changes in procedures need to be evidence based and you listen to your head, for fundamental care practice changes I listen to my heart*.

Distributing learning in a hospital seems to begin with close colleagues and then broaden out. I-7 pointing out that *switching metaphors, takes time, we learn and demonstrate by experience*, goes on to note that many staff work between units and the meaning and pace of unlearned practice differs between units: *in ITU, A&E and psychiatrics I am the professional, in Child Psychology I need to co-work much more with patients*. She feels that *only after ten years have all colleagues accepted the shift from being customer orientated to putting customers at the centre*. Working with outside professionals, such as Social Workers helps this process.

Overall summary

Reflecting on these stories, we note Boje's (2000) argument that in narrating, the storyteller herself gives structure and meaning to the story, for example in the terminology used and sequencing of events. We are particularly interested in events and actions; how the narrators interpret their individual cognitive and emotional change processes and how interactions with patients influence these processes. From an unlearning perspective three major themes, each important to the coherence of the stories appeared in coding patterns: (1) catalysts of unlearning; (2) unlearning distribution; and (3) emotional reattachments. These themes frame the professionals' experiences when they tell stories of unlearning on their journey from product-centred thinking towards a SDL built around what is now (not then) summarised in the slogan *patient centred care*.

The catalysts of unlearning cause and/or accelerate unlearning: the kick-off point. The distribution of learning means sharing their experiences with other professionals within the

hospital; and emotional reattachment includes the changes of emotions in personal level. Table-3 illustrates these themes from the unlearning narratives.

INSERT TABLE-3 ABOUT HERE

Table-3: Summary of unlearning stories from Tampere Hospital staff structured by themes

Our argument is not that listening and learning from customers results in transformational change; rather, it is that listening to customers reveals new narratives that justify a wider change of mindset (reflecting social change), in this case towards adopting a service-dominant instead of a goods-dominant approach to service delivery.

As table-3 illustrates, invariably the shift from product logic to SDL in the three narratives is catalysed by interactions with and learning from service users: listening and learning. Newell and Rosenbloom (1981) term these *learning moments*: they occurred variously during care, training, outside course or international conference. In all cases, interviewees reported musing, mind-wandering inside and outside of work: unconscious cognitions accompanying deliberative problem solving. Within the hospital I-5 noticed patient unhappiness even after a successful operation, concluding that patient subjective experience of services was unsatisfactory and began his journey towards patient-centred care. The maternity nurses followed a similar path. Patient centred care is challenging in a professional environment that uses complex medical procedures and technologies and where knowledge is unevenly distributed between professionals and doctors. External interaction with social workers and midwives encouraged psychiatric services to increase patient expectations and refocus towards care in the community.

Brook *et al* (2016) notice that the positioning of individual agents within an institutional and social context enables and constrains unlearning. Hierarchy does not appear as a barrier to unlearning distribution in Tampere University Hospital. The *taking babies home* story (see table-3) shows junior staff via unlearning creating new knowledge that they then persuade Doctors to accept. Similarly, care-in-the-community is practiced at street level between professionals, before it becomes hospital policy; also patient-centred care is implemented before senior management approval. Perhaps this is because a professional care culture can emulate the free flow of knowledge found in high-velocity environments: commitment trumps hierarchy, when allowed by the senior staff. In addition, there have been identified shifts of healthcare professionals' training from historically stiff hierarchical up-down pecking-order towards agile multidisciplinary cure and care teams. Possibly allowing junior staff members to be more proactively initiating new developments and sharing new knowledge than during earlier decades. Historically junior medical doctors and nurses are educated and mentored, when entering clinical internships and work, by senior staff members whom have the authority based on their seniority in clinical experience and knowledge (Tevameri 2014; Kallio 2015; Kuoppakangas 2015). Further, as we argue below, distributed leadership too plays an important part.

Several interviewees commented on contextual changes spurring and reinforcing how hospital professionals and the organisation view its role and in particular the need to work closely with other agencies. I-7 says it was *an eye-opener when I realised we could only effectively treat people by working closely with outside agencies, such as Social Work, recognising that their opinion is as important as mine; some things they know better than me. I'm still a professional*

but as part of a wider group of professionals. She goes on to argue for more integrated professional training and development: *we can't train in silos.*

According to Vygotsky's (1934) thinking, emotional attachment is central to learning. Table-3 shows how emotional reattachment was central in a shift from service product logic to service dominant logic. What may be surprising is the time frame: ten-years or twenty-years. Our interviewees are providing services to vulnerable people (including babies); risk-mitigation requires very lengthy periods of thought experiments, micro-pilots and constant evaluation before new service models are legitimated.

Discussion and conclusion

In this paper, we have concentrated on a shift from service product logic to service dominant logic. Our contribution is to emphasise the importance of unlearning in a shift from service product logic to service dominant logic and to illustrate some important aspect of unlearning processes.

Our data shows how important social learning/unlearning is and how it occurs at an individual level. We argue firstly, that altering attitudes (roles and relationships with users and other professionals) is not simply a new learning process. Instead, from our Vygotskian perspective, a shift from service product logic to service dominant logic necessarily involves the deep *minds-on* unlearning of previous emotional attachments, metaphors and framework (not cognitive or behavioural).

Vygotsky argued that learning contexts importantly influence how agents play an active role in learning. The most important context of unlearning is the interaction between professionals and service users in a shift from service product logic to SDL. In the context professionals' experiences are the catalysts of unlearning. As Osborne et al (2015) and Laitinen et al (2017) suggest this is a shift from services pushed by providers interested in efficiency and objective outcomes towards services pulled by users seeking effective solutions to problems from a positive subjective service experience.

Recognition that sustainable services rely on subjective satisfaction (Osborne et al 2014), meeting not only 'objective' efficiency criteria, but also positively responding to emotional touch-points (Radnor et al 2014) are important contextual influences. The suggestion of subjective satisfaction and positive responses to emotional touch-points are important, is also in line with customer experience management concept, that has been mostly studied in business firms rather than in public healthcare organisations (Gentile, Spiller & Noci 2007; Verhoef et al 2009; Klaus & Maklan 2012). However, customer experience management ideology has harboured also to private healthcare services and there are signs in this study and in recent studies that tents of the customer experience management concept are about to take footage also in public sector healthcare organisations in Finland (Viljanen-Peuraniemi 2018).

The Hospital is not an isolated context in the unlearning environment, Vygotsky (1978) is clear that influences from a wider social context and culture *precede* any unlearning in a particular organisational environment. His view seems confirmed by the stories: peoples' unlearning occurs in two dimensions: at a socio-cultural level and then at an individual and cognitive level.

Influences such as the Nordic care culture, work ethic and service user orientation precede unlearning, preparing the ground for the individual cognitions and emotional reattachment. Once the unlearning can be articulated, perhaps firstly in metaphoric terms and later more concrete service change proposals, the unlearning becomes a reciprocal experience for the individuals and other professionals. Hence, while individual narratives catalyse change, (such as from GDL to SDL), this only occurs in a social environment ready and prepared to support the changeover.

Language - like metaphors – are essential in a Vygotskian approach to learning. There is no evidence in the narratives of Klein's (1989) discarding or parking of previous knowledge. In fact, the opposite: the stories suggest attachment to previous knowledge and an emotional wrench to unlearning old ways of thinking. Like all emotional change, this takes time. Note the ruminating, musing and play interviewees use as they work through emotions towards envisioning new service metaphors and frameworks. This is especially important in a risk-laden environment where professionals need to carefully consider multidimensional risks.

Vygotsky's approach includes the idea of '*the more knowledgeable other*' meaning accepting learning from others who act as Teacher or coach during the unlearning processes. Far from change depending upon "inspirational leadership" and "great men," our stories reveal junior staff undergoing unlearning that they then distribute to senior staff (for example Nurses to Doctors). This is clearly a shift from the earlier decades healthcare professionals' distinctive indoctrination culture of junior staff in medical and nursing schools. Thus, they were indoctrinated into being humble followers of the unquestionable authority - pecking order – of the more knowledgeable senior staff without questioning their practises (Kallio 2015; Kuoppakangas 2015). Hence, it

seems that it is being appreciated within the public healthcare sector that inspiration often comes from users, with professional staff then knowing emotionally that deep change is necessary.

By way of summary: unlearning resulting in a shift from service product logic to service dominant logic begins and ends with emotions - moving from emotional discomfort with an existing service model towards emotional attachment to a new model. The hospital research shows feelings towards user's subjective service experiences to be a major influence on instigating change and guiding its outcomes. Hence, existing research implicates subjective service experience being also a major factor in creating good customer experience also in healthcare services (Assury 2010; Viljanen-Peuraniemi 2018; Laitinen & Stenvall 2016).

It seems that top-down and programmed change plays little part in a service shift unlearning, the conclusion of which takes lengthy periods of time (ten or twenty years to completion) involving time spent in unconscious cognitions, mind-wandering, informal discourse with colleagues and users, and learning from exemplar ways-of-working and small scale experimentation. Our data optimistically shows that deep and radical change in public services is possible, however, it can not be achieved by top-down pronouncements; instead allowing time for reflections, mind-wandering, listening and learning from users and discourse between professionals is necessary to allow emotional reattachment and the consequent concrete change programme that follows.

What then can managers do to make unlearning more efficient? Our data suggests a need to develop distributed leadership for the shift from service product logic to service dominant logic. Distributed leadership can (a) encourage a learning environment in which people play with new

ideas: sharing/testing/proposing/experimenting; and, (b) find it easy to experiment and distribute their learning. Our contention is that distributed leadership aids distributed learning. Gronn (2000) and Spillane's (2005) work on distributed leadership is confined to schools and founded on an idea of teacher-exceptionalism. We are uncomfortable with attributing exceptionalist traits to any public service group. Our application of distributed leadership in the hospital context revolves around dispersing authority, empowering teams and trusting professionals to want to improve services.

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Table -1 Summary of Vygotskian approach to unlearning

Vygotskian approach	Meanings
Unlearning is social	Cognitions reference culture and context
Unlearning depends on people	Agents play an active role in unlearning
Social unlearning precedes unlearning	Agent's ability to articulate (often in new metaphors) the unlearning relates to social change which firstly appear as social phenomena and are only then articulated as cognitions by individuals
The more knowledge other	Somebody acts as a teacher or a coach in an unlearning process
Zone of proximal development	The distance between agents effects on unlearning
Language – like metaphors - affects unlearning	The internalization of language tools led to unlearning
Emotional attachment	Emotional attachment is central to unlearning

Table-2 Interviewees

Interviewee	Role/responsibility	Years of experience
I-1	Maternity Nurse	20
I-2	Nurse, Sick Baby Unit	12
I-3	Nurse, Sick Baby Unit	20
I-4	Nurse, Sick Baby Unit	15
I-5	Unit Manager (previously Consultant)	25
I-6	Doctor, Child psychiatrist	20
I-7	Ward Manager, Psychiatrics	20
I-8	Charge Nurse	17
I-9	Director of Nursing	26

Table-3 Summary of unlearning stories from Tampere Hospital staff structured by themes

Narrative	Catalysts of unlearning	Unlearning distribution	Emotional reattachment
Taking babies home	<ul style="list-style-type: none"> • Listening and learning with mothers • Play and mind-wandering 	<ul style="list-style-type: none"> • Informally amongst nurses; piloted then reluctant Doctor approval 	<ul style="list-style-type: none"> • Slowly: changed over 20-years • New metaphor • Learning to trust and empower parents
Care in community: the holistic patient	<ul style="list-style-type: none"> • Listening and learning with patients and families: play and mind-wandering • International event • Lean project • Interaction with other professionals such as Social Workers and Midwives 	<ul style="list-style-type: none"> • Informally amongst staff • Small scale piloting • Practice led Hospital and Government policy 	<ul style="list-style-type: none"> • Ten-year change period • New care metaphor • Newly negotiated shared language and procedures between professionals
Patient-centred care: democratic medicine	<ul style="list-style-type: none"> • Listening and learning with patients and families • Play and mind-wandering • International event • External study • Formal research • Discourse with external professionals 	<ul style="list-style-type: none"> • Informally amongst staff • Exemplars: learning-by-doing and imitating • Hybrid change teams (organisational panel) • New standards (e.g. punctual appointments) 	<ul style="list-style-type: none"> • Ten-year change period • Evolved new practices • New metaphors • Changing Finnish society expectations of services